LAKEVIEW CHURCH

Couples Intake Packet

General Spouse 1 [complete pg 1-2]

Name: _____ Date: _____

Gender: ☐ Male ☐ Female Age: _____ Date of Birth: _____

Phone Number: _____ Address: _____

Are we allowed to contact and leave messages on this number? ☐ Yes ☐ No

How did you hear about Lakeview Counseling: _____

Do you regularly attend church, synagogue, or other religious institutions? ☐ Yes ☐ No

If yes, which one? _____

Frequency of church attendance: _____ times per month

Have you been baptized? ☐ Yes ☐ No When? _____

How often do you pray to God? ☐ Never ☐ Occasionally ☐ Often How often: _____

Current marital status: ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If engaged, married, separated, divorced, or widowed, for how long? _____

If applicable, number of previous marriages for you: _____

Please provide a brief description of your spouse: (e.g. angry and controlling; outgoing and supportive)

_____

Who all lives in the home?

_____

Personal Habits and Health

Approximately, how many hours of sleep do you get each night? _____

If there is a length of time between going to bed and falling asleep, what do you do during that time?

_____

_____

Are you presently taking any medications? ☐ Yes ☐ No

For what reasons? _____

Are you taking the medications as prescribed? ☐ Yes ☐ No

Have you used drugs other than for medical purposes? ☐ Yes ☐ No

When: _____ What: _____ Amount/Dosage: _____

Do you drink alcoholic beverages? ☐ Yes ☐ No

How much: _____ How often: _____

Have you ever been arrested? ☐ Yes ☐ No

What was the outcome? _____

Have you ever had a severe emotional upset? If so, explain: _____

_____

Counseling or Mental Health History

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the names of the therapists or programs.

Therapist's Name or Program	***Dates***	***Outcome and Diagnosis***	***Medications Prescribed (if any)***

Current

What is the problem that led you to decide to come to couple's therapy? _____

_____

Have you threatened to separate or divorce (if married) because of the current relationship problem(s)?

☐ Yes ☐ No If so, have you consulted a lawyer? ☐ Yes ☐ No

How long have you and your partner been together? _____

What initially attracted you to your partner? _____

How are the two of you similar? _____

How are the two of you different? _____

What do you do when there is conflict between the two of you? What does your partner do? _____

_____

_____

What is the area or topic that is most difficult for you to discuss with your partner? Why? _____

_____

For the next questions, answer on a scale from 1 to 10 [1=not at all, 10=extremely].

How committed are you to the relationship? _____ How much do you love your partner? _____

How much do you respect your partner? _____ Are you happy in this relationship? _____

How satisfied are you with the intimacy in this relationship? _____

LAKEVIEW CHURCH

Couples Intake Packet

General Spouse 2 [complete pg 3-4]

Name: _____ Date: _____

Gender: ☐ Male ☐ Female Age: _____ Date of Birth: _____

Phone Number: _____ Address: _____

Are we allowed to contact and leave messages on this number? ☐ Yes ☐ No

How did you hear about Lakeview Counseling: _____

Do you regularly attend church, synagogue, or other religious institutions? ☐ Yes ☐ No

If yes, which one? _____

Frequency of church attendance: _____ times per month

Have you been baptized? ☐ Yes ☐ No When? _____

How often do you pray to God? ☐ Never ☐ Occasionally ☐ Often How often: _____

Current marital status: ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If engaged, married, separated, divorced, or widowed, for how long? _____

If applicable, number of previous marriages for you: _____

Please provide a brief description of your spouse: (e.g. angry and controlling; outgoing and supportive)

_____

Who all lives in the home?

_____

Personal Habits and Health

Approximately, how many hours of sleep do you get each night? _____

If there is a length of time between going to bed and falling asleep, what do you do during that time?

_____

_____

Are you presently taking any medications? ☐ Yes ☐ No

For what reasons? _____

Are you taking the medications as prescribed? ☐ Yes ☐ No

Have you used drugs other than for medical purposes? ☐ Yes ☐ No

When: _____ What: _____ Amount/Dosage: _____

Do you drink alcoholic beverages? ☐ Yes ☐ No

How much: _____ How often: _____

Have you ever been arrested? ☐ Yes ☐ No

What was the outcome? _____

Have you ever had a severe emotional upset? If so, explain: _____

_____

Counseling or Mental Health History

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the names of the therapists or programs.

Therapist's Name or Program	***Dates***	***Outcome and Diagnosis***	***Medications Prescribed (if any)***

Current

What is the problem that led you to decide to come to couple's therapy? _____

_____

Have you threatened to separate or divorce (if married) because of the current relationship problem(s)?

☐ Yes ☐ No If so, have you consulted a lawyer? ☐ Yes ☐ No

How long have you and your partner been together? _____

What initially attracted you to your partner? _____

How are the two of you similar? _____

How are the two of you different? _____

What do you do when there is conflict between the two of you? What does your partner do? _____

_____

_____

What is the area or topic that is most difficult for you to discuss with your partner? Why? _____

_____

For the next questions, answer on a scale from 1 to 10 [1=not at all, 10=extremely/highly].

How committed are you to the relationship? _____ How much do you love your partner? _____

How much do you respect your partner? _____ Are you happy in this relationship? _____

Are you satisfied with the intimacy level in this relationship (e.g. frequency, enjoyment)? _____